

CATEGORY 1

REGULATORY INFORMATION DISTRIBUTION SYSTEM (RIDS)

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 ACCESSION NBR:9607240241 DOC.DATE: 96/07/17 NOTARIZED: NO DOCKET #
 FACIL:STN-50-530 Palo Verde Nuclear Station, Unit 3, Arizona Publi 05000530
 AUTH.NAME AUTHOR AFFILIATION
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 LEVINE,J.M. Arizona Public Service Co. (formerly Arizona Nuclear Power
 RECIP.NAME RECIPIENT AFFILIATION

SUBJECT: LER 96-001-00:on 960621,inaccurate gas calculations for post
 accident sampling sys occurred.Caused by surveillance test
 worksheet errors.Independent investigation of event being
 conducted.W/960717 ltr.

DISTRIBUTION CODE: IE22T COPIES RECEIVED:LTR 1 ENCL 1 SIZE: 5
 TITLE: 50.73/50.9 Licensee Event Report (LER), Incident Rpt, etc.

NOTES:Standardized plant.

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Arizona Public Service Company

PALO VERDE NUCLEAR GENERATING STATION
P.O. BOX 52034 • PHOENIX, ARIZONA 85072-2034

192-00975-JML/BAG/DRL

July 17, 1996

JAMES M. LEVINE
VICE PRESIDENT
NUCLEAR PRODUCTION

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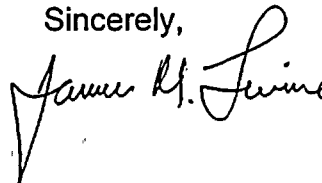
Dear Sirs:

Subject: Palo Verde Nuclear Generating Station (PVNGS)
Unit 3
Docket No. STN 50-530
License No. NPF-74
Licensee Event Report 96-001-00

Attached please find Licensee Event Report (LER) 96-001 prepared and submitted pursuant to 10CFR50.73. This LER reports a Technical Specification (TS) violation of 3.3.3.1 due to an oversight by both the Surveillance Test (ST) preparer and reviewer in calculating gas concentrations for the Post Accident Sampling System (PASS) on three (3) different occasions during 1995.

In accordance with 10CFR50.73(d), a copy of this LER is being forwarded to the Regional Administrator, NRC Region IV. If you have any questions, please contact Burton A. Grabo, Section Leader, Nuclear Regulatory Affairs, at (602) 393-6492.

Sincerely,



JML/BAG/DRL/pv

Attachment

cc: L. J. Callan (all with attachment)
K. E. Perkins
K. E. Johnston
INPO Records Center

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IE22

9607240241 960717
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LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) Palo Verde Unit 3	DOCKET NUMBER (2) 0 5 0 0 0 5 3 0	PAGE (3) 1 OF 0 4
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TITLE (4)
Inaccurate Gas Calculations For The Post Accident Sampling System (PASS)

EVENT DATE (5)			LER NUMBER (6)			REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)	
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	MONTH	DAY	YEAR	FACILITY NAMES	DOCKET NUMBERS
0 6	2 1	9 6	9 6	- 0 0 1	- 0 0	0 7	1 7	9 6	NA	0 5 0 0 0 0
									NA	0 5 0 0 0 0

OPERATING MODE (9) 1		THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)									
POWER LEVEL (10) 1 0 0		20.402(b)		20.405(c)		50.73(a)(2)(v)		73.71(b)			
		20.405(a)(1)(i)		50.36(c)(1)		50.73(a)(2)(v)		73.71(c)			
		20.405(a)(1)(ii)		50.36(c)(2)		50.73(a)(2)(vii)		OTHER (Specify in Abstract below and in Text, NRC Form 366A)			
		20.405(a)(1)(iii)	<input checked="" type="checkbox"/>	50.73(a)(2)(i)		50.73(a)(2)(viii)(A)					
		20.405(a)(1)(iv)		50.73(a)(2)(ii)		50.73(a)(2)(viii)(B)					
		20.405(a)(1)(v)		50.73(a)(2)(iii)		50.73(a)(2)(x)					

LICENSEE CONTACT FOR THIS LER (12)	
NAME Burton A. Grabo, Section Leader, Nuclear Regulatory Affairs	TELEPHONE NUMBER AREA CODE 6 0 2 3 9 3 - 6 4 9 2

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)										
CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRPDS	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRPDS	

SUPPLEMENTAL REPORT EXPECTED (14)						EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR
<input type="checkbox"/> YES (If yes, complete EXPECTED SUBMISSION DATE) <input checked="" type="checkbox"/> NO									

ABSTRACT (Limit to 1400 spaces, i.e., approximately fifteen single-space typewritten lines) (16)

On August 30, 1995, at approximately 1310 MST, Palo Verde Unit 3 was in Mode 1 (POWER OPERATION), operating at approximately 100 percent power when Unit 3 Chemistry personnel, during the monthly performance of 74ST-9SS04, Post Accident Sampling System (PASS) (IP) Functional Test, in accordance with Technical Specification (TS) 4.3.3.1 and Table 4.3-3, 3, miscalculated the amount of dissolved hydrogen within the Reactor Coolant System (RCS) and indicated that the criteria had been met for test acceptance. 74ST-9SS04 was subsequently performed on September 27, 1995, and 74ST-9SS03, Post Accident Sampling System Surveillance (18 month test) on November 25, 1995, with like results. 74ST-9SS04 was not required during October 1995 because the Unit was in an outage. This issue was originally self-identified on May 29, 1996, while retrieving archived data for PASS hydrogen analyses. Based on subsequent investigation, the PASS was determined to have been administratively inoperable since approximately 1310 MST on August 30, 1995, and to have exceeded the 7 day limit for inoperability per T.S. 3.3.3.1 at 1310 MST on September 6, 1995. Further, the investigation determined that the PASS was operable when 74ST-9SS04 was satisfactorily completed on December 22, 1995. Therefore, Palo Verde Unit 3 operated for approximately 75 days with PASS inoperable. A preliminary evaluation determined that the apparent cause of the event was surveillance test (ST) worksheet errors attributed to poor written communication and inattention to detail. There have been no previous similar events reported pursuant to 10CFR50.73.

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TEXT

1. REPORTING REQUIREMENT:

This LER 530/96-001-00 is being written to report a condition prohibited by the plant's Technical Specifications (TS) as specified in 10CFR50.73 (a) (2) (i) (B).

Specifically, at approximately 1310 MST on August 30, 1995, Palo Verde Unit 3 was in Mode 1 (POWER OPERATION), operating at approximately 100 percent power when Unit 3 Chemistry personnel (utility, nonlicensed) during the monthly performance of 74ST-9SS04, Post Accident Sampling System (PASS) (IP) Functional Test, in accordance with Technical Specification (TS) 4.3.3.1 and Table 4.3-3, miscalculated the amount of dissolved hydrogen within the Reactor Coolant System (RCS) and indicated that the criteria had been met for test acceptance. 74ST-9SS04 was subsequently performed on September 27, 1995, and 74ST-9SS03, Post Accident Sampling System Surveillance (18 month test) on November 25, 1995, with like results. 74ST-9SS04 was not required during October 1995 because the Unit was in an outage. This issue was originally identified on May 29, 1996, while retrieving archived data for PASS hydrogen analyses. Based on subsequent investigation, the PASS was determined to have been inoperable administratively (the PASS was fully functional for the entire period) since approximately 1310 MST on August 30, 1995, and to have exceeded the 7 day limit for inoperability per TS 3.3.3.1 at 1310 MST on September 6, 1995. Further, the investigation determined that the PASS was operable when 74ST-9SS04 was satisfactorily completed on December 22, 1995.

2. EVENT DESCRIPTION:

Prior to the identification of the event, the Post Accident Sampling System (PASS) System Engineering duties had recently changed hands. As a part of system turnover, the new PASS engineer requested that a PASS team be assembled to assess and provide a system baseline from which future actions could be determined.

One of the items identified at the first meeting held on May 8, 1996 was the need to evaluate the trend of PASS pressurized sample hydrogen drift associated with the monthly performance of surveillance test (ST) procedure 74ST-9SS04, "PASS Functional Test."

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TEXT

During the evaluation of historical records by Chemistry Support, it was identified that hydrogen data recorded in ST package 74ST-9SS04-3, dated 10/03/95, was inconsistent with typical surveillance data. Further evaluation indicated that the PASS pressurized hydrogen calculation on the data sheet, Appendix "B" of 74OP-3SS02, "Operation of the Post Accident Sampling System," was incorrectly performed, and that had the calculation been performed correctly, the ST would have failed.

After identifying the failed ST, a review was conducted to bracket the failure with correctly performed STs. During this review, two (2) additional STs, 74ST-9SS04-3 (monthly functional test) dated 8/30/95 and 74ST-9SS03-3 (18 month test) dated 11/27/95, were found to have similar errors resulting in three (3) consecutive ST failures. These three (3) consecutive failures were verified to be bracketed with correctly performed surveillance tests, 74ST-9SS04-3 dated 08/01/95 and 74ST-9SS04-3 dated 12/22/95.

3. ASSESSMENT OF THE SAFETY CONSEQUENCES AND THE IMPLICATIONS OF THIS EVENT:

The Bases for the TS SR 4.3.3.1 (Radiation Monitoring Instrumentation) is to ensure that: (1) the radiation levels are continually measured in the areas served by the individual channels and (2) the alarm or automatic action is initiated when the radiation level trip setpoint is exceeded.

PASS sample points are defined in Regulatory Guide 1.97, "Instrumentation of Light-Water-Cooled Nuclear Power Plants to Assess Plant Conditions During and Following an Accident," as Type E, Category 3. Type E measurements are to aid control room staff and emergency support staff in assessing radiological impact and in minimizing the risk to the public for the long term mitigation of an event. Type E requirements are not required for safe shutdown of the plant. Since the error was administrative in nature, the PASS was always in a condition to allow full function if called upon in an emergency. Therefore, there is no safety function associated with the PASS.

This event did not adversely affect the safe operation of the plant or the health and safety of the public. The event did not result in any challenges to the fission product barriers or result in any releases of radioactive material. Therefore, there were no adverse safety consequences or implications as a result of this event.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

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Palo Verde Unit 3		YEAR	SEQUENTIAL NUMBER	REVISIO NUMBER			
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TEXT

4. CAUSE OF THE EVENT:

An independent investigation of this event is being conducted in accordance with the APS Corrective Action Program. As part of the investigation, a root cause is being performed. A preliminary evaluation, based on available information, has determined that the apparent cause was ST worksheet errors attributed to poor written communication and inattention to detail (SALP Cause Code A: Personnel Error).

No unusual characteristics of the work location (e.g., noise, heat, poor lighting) directly contributed to this event. If information is developed which would significantly affect the reader's understanding or perception of this event or if the final evaluation results differ from this determination, a supplement to this report will be submitted.

5. STRUCTURE, SYSTEM, OR COMPONENT INFORMATION:

Although the PASS was inoperable for failure of a surveillance requirement, there were no component or system failures involved in this event. No failures of components with multiple functions were involved. No failures that rendered a train of a safety system inoperable were involved. There were no safety system responses and none were necessary.

6. CORRECTIVE ACTIONS TO PREVENT RECURRENCE:

An independent investigation of this event is being conducted in accordance with the APS Corrective Action Program. The investigation is expected to be completed by July 21, 1996. Actions to prevent recurrence are being developed based on the results of the investigation and will be tracked to completion under the APS Commitment Action Tracking System (CATS).

7. PREVIOUS SIMILAR EVENTS:

Although there have been previous events reported pursuant to 10CFR50.73 in the last three years for TS surveillance requirements not being satisfied, the causes discussed in the previous events have not been similar to this event. Therefore, the corrective actions of the previous events would not have prevented this event.

